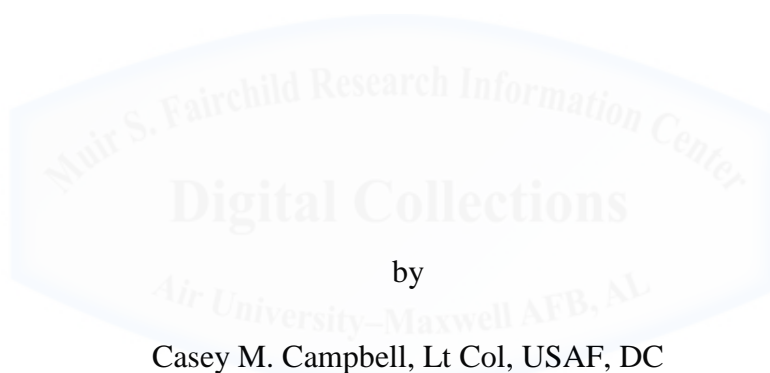


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TRUSTED CARE IN THE AIR FORCE MEDICAL SERVICE:
PRACTICAL RECOMMENDATIONS FOR TRANSFORMATION



by

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A Research Report Submitted to the Faculty

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Biography

Lt Col Casey M. Campbell is a student at the Air War College, Air University, Maxwell AFB, Alabama. He graduated from Wake Forest University in 1998 and The University of Texas Health Science Center in 2003, after which he received a direct commission in the U.S. Air Force Dental Corps. As a dental officer, he completed his residency in periodontics in 2006 at The University of Texas Health Science Center and Wilford Hall Medical Center, Lackland AFB, Texas. He went on to be an instructor in the general dentistry residency at the U.S. Air Force Academy, followed by a position on the teaching staff at the periodontics residency at Joint Base San Antonio-Lackland. Prior to his current assignment, he served as Commander of the 377th Dental Squadron and Deputy Commander of the 377th Medical Group at Kirtland AFB, New Mexico. After graduation, he will serve as Deputy Commander of the 31st Medical Group at Aviano AB, Italy.

Abstract

As the U.S. Air Force Medical Service (AFMS) continues its journey toward becoming a high reliability organization (HRO), the service is presented with a number of challenges at all levels of implementation—from the strategic down to the tactical. Importantly, the tactics used in new military programs, policies, and transformations often backfire, leading to cynicism, loss of the “hearts and minds” of those who will be implementing the new system at the end-user level, and ultimately a subpar end product. We can gain much wisdom from literature on effectively leading changes, from private organizations and companies that have pursued similar transformations, and from previous failed implementations of military programs. Although the AFMS faces a number of significant obstacles in its transition to the HRO culture, I propose a number of recommendations which can ease the transformation at the tactical level and significantly benefit the planning and successful implementation of Trusted Care Transformation across the AFMS.

Introduction

According to former Secretary of Defense Chuck Hagel in late 2014, the Military Health System (MHS) “can do better.” Earlier that year, the Veterans Health Administration (VHA) was thrust into the national spotlight as a devastating scandal emerged, stemming from overwhelming evidence of mismanagement and compromises in patient safety and quality throughout the organization. In June, Hagel ordered a comprehensive review of the MHS, in an effort to confirm or deny similar quality/safety issues within the Department of Defense (DoD).¹ On 29 August 2014, the MHS Review was published, identifying no critical errors on par with those seen in the VHA system, although it made strategic recommendations aimed at improving patient safety and quality of care. On 1 October 2014, Hagel signed a memorandum instructing the Assistant Secretary of Defense for Health Affairs to immediately begin the development of a framework to lead the MHS to becoming a “top performing health system” and a “high reliability organization” (HRO).²

Even before the publication of this memorandum and certainly ever since, Air Force Medical Service (AFMS) leaders have engaged in the effort to become an HRO, expending time, resources, and manpower on improving patient safety. However, as historically encountered in the innumerable new policies, programs, and transformations both within and outside of the AFMS, change-makers often make errors in implementation which can compromise the effectiveness of new ideas. Errors like these—even minor ones—unfortunately create undesired delays in implementation of programs or, at worst, completely compromise the programs’ adoption and engagement by the masses, thus leading to an uphill struggle to create beneficial change.

This paper addresses potential AFMS-specific stumbling blocks which could delay, hinder, or create unnecessary angst in the adoption of the HRO concept, and presents my recommendations for senior AFMS leaders as they lead this transformation. Notably, my intent is not to fully describe high reliability theory (HRT) and concepts, strategic leadership principles, “change management” theory, or how to implement an HRO culture in the AFMS; there are already numerous well-versed leaders who are aware of these principles pursuing these goals. Rather, my intent is to explore obstacles unique to the AFMS enterprise which should be addressed in order to maximize the strategic implementation plan and ultimately the HRO culture. Finally, I present my proposed recommendations particular to the AFMS and its ethos, as assessed from my experiences amidst 13 years as a clinician, educator, commander, and emerging leader.

Thesis

By taking into account a few specific, targeted principles and lessons learned from civilian healthcare organizations and prior difficulties in previous programs implemented in the AFMS, the service can maximize its strategic effectiveness in implementing the HRO culture throughout the AFMS enterprise.

High Reliability in the MHS and AFMS

The MHS is one of the largest healthcare systems in the nation with over \$49 billion in spending in FY14.³ In 2014, the MHS Review reported only 66% positive responses regarding “overall perception of patient safety” using 2011 data,⁴ and further showed that safety self-assessment scores in the 2008-2011 timeframe diminished in the key areas of teamwork, leadership promoting a safety culture, continuous improvement, and non-punitive responses to errors and mistakes, while staffing remained “poor” over the same time interval.⁵ The Review

went on to state, “Due to the limited number of national benchmarks in patient safety, it is not possible to assess whether the MHS has a culture of safety.”⁶ Nonetheless, Hagel acknowledged the MHS “generally performs as well as the private sector in the delivery of safe, quality care . . . [but] we can do better.”⁷

On 28 August 2015, the AFMS Trusted Care Transformation Task Force Charter was signed by the Surgeon General, chartering a team tasked to “synchronize and integrate all AFMS efforts to achieve high reliability.”⁸ The AFMS HRO concept has been termed “Trusted Care,” and the prescribed changes will be widespread and all-encompassing—hence being labelled a *transformation* versus simply a new program or policy.

High-reliability organizations have been described as those which exhibit “exemplary performance”⁹ in an “unforgiving . . . environment rich with the potential for error”¹⁰, particularly in circumstances in which the price for failure is of critical significance, i.e., danger to human life and/or excessive monetary expense. Classic examples of HROs include nuclear power plants and aircraft carriers, each of which is a highly complex organization where small errors can lead to extreme consequences. Normal Accident Theory would tend to predict a higher error rate than truly encountered,¹¹ thus these organizations’ success rates deem them “highly reliable.”¹² Importantly, HRT is not based on striving for invariance and repeatability, but rather focuses on continuously managing fluctuations via highly-active yet “stable cognitive processes” constantly surveying for risks and possible consequences.¹³ In healthcare, for instance, every patient and procedure presents unique demands, thus rote repeatability can lead to dire consequences, whereas stable cognitive processes (amidst constantly changing situations) contribute to a consistent focus on non-failure.

As described by Weick et al., HRT's key concepts include the preoccupation with failure, a reluctance to simplify, a commitment to resilience, and underspecified structuring (a rather un-military concept), all of which lead to "mindfulness" versus the proverbial auto-pilot mentality. In combination, these processes improve the ability to discover and manage the unexpected, thus promoting high reliability (HR).¹⁴

Potential Stumbling Blocks

The complications in the pursuit and implementation of HR, particularly as it relates to healthcare, are extensive and well-documented. These complications include difficulties engaging and educating front-line staff, reducing complexity, using a single strategy versus multiple, etc., most of which have been discussed previously.¹⁵ In this section, I focus on five stumbling blocks specific to the AFMS and its culture:

1. Widespread cynicism amidst change
2. Losing sight of the main motivator
3. Personnel issues
4. Difficulty finding time for something new
5. Inability to maximize both efficiency and reliability

Widespread cynicism amidst change

It is difficult to engage an audience which has encountered so much "change" that it becomes a struggle for them to delineate why one particular change is different and more worthwhile than all the other changes they have seen implemented (and often later de-implemented) throughout their careers. For DoD personnel, change is a consistent part of the battle rhythm. Airmen routinely move to assignments at other bases, Air Force Instructions (AFIs) and Operating Instructions (OIs) are routinely rewritten, inspection processes change,

contractors are here today and gone tomorrow, and commanders serve short tours and then move on. As a result, AFMS personnel regularly see new programs come and go, e.g., the latest computer-based training (CBT) module or local physical fitness policy. With new commanders come new programs, and when leadership changes, old programs tend to diminish and new programs arise. As a result of this norm (“wait long enough and it will change”), our personnel have become jaded by what they perceive as the latest and greatest bright idea¹⁶—even though many are worthwhile and can increase efficiency (for example, Lean Daily Management (LDM)). In the past few years alone, our medics have adapted to a sweeping new self-inspection process, learned to use the Management Internal Control Toolkit, kept on top of an increasing number of CBTs, tackled their LDM goals at many Medical Treatment Facilities (MTFs), etc., and often with less manpower and resources in their duty sections than a few years prior. Consequently, as AFMS leaders pursue HR enterprise-wide, our medics will likely perceive this as being a new program (even if they hear repeatedly that it is a “transformation”) which they feel they will have to fit into their steady state of busyness. Even though the HRO concept helps mitigate many of our difficulties and improve patient safety, we run the risk of our Airmen not recognizing these potential benefits unless a significant effort is made to help curtail the stigma of HRO being just the latest in the unending string of changes.

Losing sight of the main motivator

When comparison-based metrics and MTF rankings are constantly front and center at our meetings, the motivation for success runs the risk of being less patient-focused and instead becomes increasingly about advancing within the major command (MAJCOM) or AFMS, or about keeping the wing commander convinced the MTF is doing well without having to explain to him/her why the MTF is in the lower tier of some-or-other ranking, or improving a metric

which is meeting the goal but is nonetheless ranked significantly below other MTFs. As in other Air Force organizations, the AFMS uses surrogates (i.e., metrics) to assess mission accomplishment and as evidence of progress in meeting goals. Unfortunately, these metrics too often distract attention from the primary goal(s) and motivator(s), consequently leading MTF leaders to get caught up in a metric-driven, “where does my MTF rank?” culture. Comparisons to other MTFs are always on the screen during teleconferences and now (most recently) on the quarterly wing commander’s dashboard. Instead of simply stating how the commander’s MTF is performing, the dashboard assesses how the MTF ranks in comparison to others in the MAJCOM and/or AFMS. While on the surface this may be beneficial in publically showing performance and even creating a competitive spirit, it has the potential to backfire in the pursuit of HR.

Ceaseless comparison-based metrics and rankings bring about the perceived need to steer valuable resources in order to improve the ranking, for example, to go from being #7/9 to a higher ranking. At the same time, there is the risk that patient safety (as the key motivator) becomes a by-product attained in the pursuit of improving metric rankings, when the opposite should be the case. The motivation becomes fear of perceived failure among peers and commanders (and effects on careers), versus the more wholesome and worthy motivator of doing what is best for patients. A better motivator is simply doing the right thing; rankings should be an afterthought, *less visibly and frequently seen front and center*.

Comparison-based metrics create potentially unhealthy competition when the goal might otherwise be coordination and teamwork between MTFs; the former detracts from the latter. One should ask if there is really an expectation for MTFs to coordinate as one team en route to HR when the system in which they exist is engineered toward inter-MTF competition publicized monthly, always comparing a particular MTF to all the others.

To expound on a key principle of author Simon Sinek¹⁷, if the “why” is coming from the wrong area, the ambition and dedication to the goal can be sidetracked or lost altogether. In effect, doing a worthy endeavor for the wrong (or at least skewed) reasons creates less enthusiasm, less engagement of hearts and minds, and serves as a lower-tier “why”. My former wing commander used to say, “There can be *only one* #1 priority,”¹⁸ and it is quite possible that constant comparison-based metrics and rankings can be a fatal distraction. I propose the AFMS should re-think its overuse of comparison-based metrics which breeds unnecessary and counterproductive overreliance on *competition*, detracting from higher-impact sources of motivation.

Personnel issues

If transforming healthcare in the private sector is difficult (which it is),^{19,20} we can reasonably assume it will be even more so in the AFMS, if for no other reason than because it is exceedingly difficult in the military to eliminate those who resist change. In private healthcare organizations, personnel can be hired and fired if necessary, a requirement for implementing Lean strategy (see endnote).²¹ Accordingly, when a private sector organization is striving to implement HR and is encountering personnel-based friction and resistance to change (inertia), one powerful tool in their armamentarium is the ability to remove particular employees and hire new ones willing to adapt to the change. While most personnel in a particular military organization may be fully on board with changes in policy and/or transformation, the process for getting rid of those who are chronic resisters is tedious and occasionally impossible. That being the case, it should be expected that personnel issues alone make HRO-related transformation more painstaking in a military environment, as compared to similar implementation in the private sector. In the AFMS in particular, the ability to hire, fire, and shuffle is drastically limited

compared to civilian healthcare organizations. Therefore, the inability to shape personnel will likely make the transformation more difficult, particularly when considering the potential for inertia detailed above.

On a related note, active duty medics are constantly cycling with gains and losses each year. This creates a greater challenge to “gel” as a team, compared with private organizations which tend to have less ingress and egress of personnel annually.

How to find the time for something new

As detailed in the literature, a vital condition in pursuing HR is the need for active, regular presence of highly-placed leaders visible at the front lines,²² a premise iterated to me by the AFMS Director of the Trusted Care Transformation Task Force, Colonel Linda Lawrence.²³ Unfortunately, MTF leaders are significantly tasked already and it is difficult to find the “white space” necessary to continually be visible at all MTF echelons. A highly-publicized article by the U.S. Army War College captured the sentiment that new “things” are constantly added to military troops’ to-do lists by higher headquarters, but rarely is anything removed.²⁴ Even in the private sector, during the pursuit of HR it was found that “over half of teams reported that . . . insufficient time [to get all their work done] significantly deterred their progress.”²⁵ Based on what I have seen, MTF leaders’ task lists routinely include numerous committees, functions, attention to metrics, creation and analysis of PowerPoint slides, teleconferences, wing meetings, administrative taskers, writing and reviewing minutes, self-inspection forums, reading AFIs and OIs, LDM rounds, feedback, performance reports, awards, appraisals, ceremonies, disciplinary issues, personal clinic time, brown bag luncheons, civic events, dinners, morale events, graduations, and the list goes on. As a result, AFMS senior leaders should expect MTF-level leaders to undoubtedly be wondering how to fit into their standard work day the necessary

coaching, safety huddles, and an overall active, sustained presence at the front lines. MTF leaders will almost certainly understand the importance of HR, but will be thinking of the limited number of hours in the day and wondering what will have to slip in order to make room. The question on their minds will be, “What are AFMS and line leaders willing to ‘let go of’ so I can have time to focus on the #1 priority of patient safety?”

Inability to maximize both efficiency and reliability

As the AFMS struggles to cope with continually decreasing resources amidst budgetary constraints, the push for HR will be all the more difficult because HRT by definition does not espouse efficiency as a goal, and in fact the two may be mutually exclusive. As Weick and Sutcliffe point out in no unclear terms, the cost of reliability is efficiency. In contrast to HROs, organizations striving for maximum *efficiency* tend to seek “stable activity patterns and variable cognitive processes,” whereas HROs strive for the opposite—stable cognitive processes amidst highly variable patterns of activity, *at the cost of efficiency*.²⁶ In HROs, the price (efficiency) is considered a worthwhile expense, and this is particularly true in healthcare organizations. Additionally, resources historically tend to become more scarce as organizations achieve success in progressing toward HR,²⁷ which can make efficiency even less likely. That being the case, if the AFMS (and DoD as a whole) is continually challenged to do the same or more with less personnel/resources/funding (thus by definition be more efficient), this can directly antagonize the pursuit of HR. In short, pennies and personnel are not typically pinched in HROs such as nuclear power plants and air traffic control, because disaster is significantly more expensive.

Recommendations

Despite these and other stumbling blocks, the benefits of HR transformation are realistic and worthwhile. As the AFMS aspires to be a premier and safe healthcare organization on par

with lauded organizations such as Memorial-Hermann²⁸, we must overcome the vulnerabilities specific to our enterprise. Accordingly, I propose the following recommendations for optimizing the HRO transformation plan:

1. Actively prepare for cynicism and at least a temporary drop in morale
2. Minimize comparison-based metrics and rankings
3. Assist MTF personnel in creating the “white space”
4. Intentionally strive for specific, targeted buy-in of clinical leaders
5. Recognize only one “#1 priority”
6. Emphasize mindfulness, versus auto-pilot
7. Plan to sacrifice some degree of efficiency for high reliability
8. Use bold, not bland, signage

Actively prepare for cynicism and at least a temporary drop in morale

The AFMS should expect and actively prepare for the inevitable cynicism which can occur even at the upper leadership levels. Throughout his organization’s journey toward Lean transformation, John Toussaint, former CEO of ThedaCare, describes the palpable cynicism he worked against during his tenure. When employee opinion scores and physician satisfaction scores were the worst they had ever been in ThedaCare’s history, he told his board members, “It appears I am destroying the place. Do you want me to keep on going?” His board members unanimously agreed he should keep pursuing the transformation, and “the fact that morale was declining indicated we were making serious change.”²⁹ Toussaint described this as a “rough patch” which all healthcare organizations will undergo at some time or another amidst transformation. Importantly, he points out the extreme importance of his board members

enduring the cynicism during the rough patch. To summarize Toussaint, the morale may get worst just before the biggest improvements are noticed.

Though it may seem obvious, I believe it would be worthwhile to actively ensure AFMS and MTF leaders are *expecting and preparing* for cynicism and/or a dip in morale. When morale drops *unexpectedly*, there can be a sense of frustration or even panic, but when people are prepared for it and expect it as a natural part of the process, they may be more likely to pull through and keep their own dedication and morale at a higher level. Amidst the cynicism, the message should focus on the value of patient safety (which our motivated medics can rally around), versus what is unfortunately too often summarized as, “this is the new AFI or policy so we must do it.” We need to transmit the message that not only are HR concepts good for patients, but they are mandated from the highest level—not simply by MTF leaders, AFMS leaders, or even MHS leaders, but by the Secretary of Defense. Our senior leaders are well aware of this, but the typical medic is probably unaware.

Minimize comparison-based metrics and rankings

If it is true that routinely broadcasting comparison-based metrics and rankings causes MTF leaders to become overly focused on not being low-ranked in the MAJCOM or AFMS, thus creating an alternate, lower-impact source of motivation for improvement, the AFMS must curtail the frequency and publicity of comparative metrics during the HRO transformation. A stronger motivator is the simple desire for improvements to patient safety—a motivator healthcare professionals would probably rather it be—which can more effectively help the AFMS and patients attain a better product. It is not worth risking the more effective motivator being subjugated to being secondary to on-screen comparative metrics (“how does my MTF rank compared to others in my MAJCOM?”, “did we increase from last month?”, “what will the wing

commander think?”, etc.). If the “why” becomes infected or even corrupted by anything secondary to the more altruistic “why”, the trade-off is counterproductive and stymies high-impact progress.

Accordingly, I recommend the AFMS remove the rankings from the wing commander’s dashboard, choosing instead to simply state the metric and a phrase such as “meeting standards” versus “#7/10 in ACC”. In this example, if the MTF is meeting the established standard and happens to be ranked #7, the perception of being subpar (at least by comparison to the other nine MTFs in the MAJCOM) can create a desire by MTF leadership to improve the particular metric to appear better to the wing commander by upgrading the ranking. Thus, the MTF unnecessarily expends time and resources to raise the #7 to a higher rank (to appear better by comparison) and loses focus on the main goal of pursuing HR. I am not arguing that metrics are not valuable (indeed they are), but rather that the distraction created by comparison-based, competition-based metrics can be minimized if they are emphasized less frequently—provided the MTF is meeting established standards.

I am not the first to make this claim. Notably, “publically reporting data” to increase “competition among provider organizations” is described by Mark Chassin of The Joint Commission (TJC) as a concept which has “been in vogue” in the past,³⁰ hinting that this practice can be a distraction from HRO progress. In short, if MTF leaders are thrust into a competitive environment measured by unending comparative metrics and rankings during teleconferences and the like, leaders will naturally expend time, energy, brainpower, and resources toward surrogate ends which have less innately motivational impact on the pursuit of HR. Or put another way, when the goal (whether stated or unstated) is continually improving one’s own rankings, people tend to make changes because they *have* to, at the expense of making

changes because they *want* to, and *want*-based changes have the propensity to make higher impacts.

Assist MTF personnel in creating the “white space”

With regard to meetings, Toussaint states they should be “minimized . . . standardized . . . [and] streamlined,”³¹ therefore the AFMS and MTFs should likewise put focused effort into giving necessary time back to MTF personnel by consolidating and streamlining the many meetings at all levels of the organization. He further states, “It is difficult to imagine a hospital getting close to high reliability if quality is merely one of many competing priorities.”³² Few would argue the administrative burden on MTF leaders is significant, and with the upcoming transformation, they will need even more time to focus on implementing changes in their organizations. If there is the possibility of decreasing the number of metrics tracked by the AFMS, this will alleviate some of the time burden on MTF leaders and subordinates alike. Most metrics require one or more people to measure them, track them, brief them, email them, etc., all of which use valuable time. The number of metrics could be decreased significantly with no compromises (and perhaps improvements due to recaptured time) in patient care. For example, the AF Dental Service uses only seven key metrics to capture its mission accomplishment. Additionally, making an effort to focus less on the creation of PowerPoint slides would give much time back to Airmen working to implement an HRO culture. Every minute an AFMS medic is not working on a PowerPoint slide, he/she could be doing his/her job more effectively, aiming for patient safety

And as mentioned above, if ranking-based metrics can be minimized (except when an MTF is failing to meet an established standard), this would help to avoid inefficient and unnecessary efforts geared toward improving metrics which otherwise require no improvement.

As a recently retired AF Dental Corps chief once said, “Sometimes a B+ is good enough,”³³ implying the effort expended in striving for the A+ consumes resources which should instead be used on more worthy endeavors, e.g., all the necessary adjustments required in HROs.

Intentionally strive for specific, targeted buy-in of clinical leaders

While HRO transformation absolutely requires top-down engagement, front-line clinical leaders “are essential to the success of any quality initiative,” they “must routinely champion quality improvements,” and they “need to be visible and active enthusiasts for quality.”³⁴ For HR to be attainable, our leaders must espouse to their teams, “Stop me if I’m about to make a mistake,” by being humble, proactive, and actively fighting perceptions that they are unapproachable. For example, to the pharmacy staff, providers should state, “Call me ASAP if my prescription is potentially incorrect,” and should be thankful and encourage good catches. Clinical leaders should lead with the mantra, “We’re all in this together, so always speak up if I or anyone else is potentially going to make a mistake.”

These seem obvious, yet in healthcare organizations the attitude is too often quite the opposite. According to the Institute for Safe Medication Practices, the top three intimidating behaviors by physicians are failure to return phone calls or pages, condescending language, and impatience with questions.³⁵ Chassin praises the “Code of Mutual Respect” at Maimonides Medical Center which strictly forbids the intimidation some clinicians create when team members second-guess or question them.³⁶ Although I do not suspect this problem exists in the AFMS to a large degree, we cannot be too safe in avoiding it. I recommend our MTF Chiefs of the Medical Staff randomly, anonymously poll staff regarding individual providers’ intimidation versus willingness to listen.

It is also vitally important to specifically target nurse managers to ensure their buy-in of HR concepts. One author states, “Nurse managers are the most important keys to embedding consistency and reliability throughout the organization and, therefore, are the keys to building HROs in healthcare.”³⁷ She goes on to describe nurse managers as “the powerhouses to get things done; when this group is working in synergy, magic happens everywhere.” If nurse managers are largely responsible for the culture of their units, transforming the AFMS into an HRO is an aimless pursuit unless their hearts and minds are engaged in it.

Recognize only one “#1 priority”

As apparent as it may seem, in pursuing HR it will be crucial to champion patient safety as the true (and only) “#1 priority”. This could be challenging at bases which verbally espouse various #1 priorities—PRP, flyers, individual medical readiness, or whatnot. For example, at bases where wing commanders tout nuclear surety as the #1 priority, it can present a challenge for MTF commanders to describe “patient safety” as being the #1 priority unless they deliberately ensure the two are woven together. Any “#1 priority” confusion decreases the buy-in from all levels of the MTF. Therefore, MTF commanders must involve wing leadership in vouching for this HR-based #1 priority so all levels of leadership show themselves to be on the same page. The power of solidly and repeatedly advocating for a single #1 priority is demonstrated well by the huge successes achieved by Paul O’Neill, former CEO of Alcoa, who ensured everyone knew creating a safe workplace was his company’s primary job. “He unleashed the creativity of every individual [to] create an environment of continuous improvement,” and his company’s successes in that endeavor are well known.³⁸

Emphasize mindfulness, versus auto-pilot

AFMS and MTF leaders should refrain from describing particular safety-based procedures as needing to be on “auto-pilot”—such as time-outs, countdowns, handoffs, etc. Instead, the emphasis should be on active and deliberate mindfulness³⁹ during these events, whereas auto-pilot by its very nature emphasizes mindlessness in an effort to create easier default routines. Obviously, time-outs and the others are critically important, but refraining from striving for an auto-pilot mentality (or even the use of the term “auto-pilot”) will more precisely focus medics on the culture of HROs. On aircraft carriers, every thought process is exquisitely active; *nothing is on automatic*.

Plan to sacrifice some degree of efficiency for high reliability

The AFMS may have to resist the urge to push for simultaneous improvements in both reliability and efficiency, which leading HRO experts have explained are incompatible aims that have a tendency to antagonize one another.⁴⁰ There should be an understanding that HR is not free, but rather it does come at a cost. While true, this is probably not a palatable concept, given the reality of working in an increasingly constrained budgetary environment. Even the DoD’s *CPI/Lean Six Sigma Guidebook* discusses the concept of balancing efficiency and reliability, implying both cannot be pursued and improved in tandem.⁴¹ But is efficiency a hopeless commodity when one is striving for HR? Not all experts necessarily agree, namely TJC’s Chassin who advocates Lean strategy (a well-known efficiency enabler)⁴² as being of paramount necessity in achieving HR,⁴³ implying efficiency (in this case Lean) may not always hinder reliability. Similarly, Colonel Lawrence stated she expects to attain increased efficiencies as the AFMS makes its processes safer; as we strive to eliminate waste (in the form of dollars, time, and processes), both reliability and efficiency can potentially improve together.

Use bold, not bland, signage and colors

Banners and signage in MTFs are often sterile and unimaginative (i.e., they usually maintain a nondescript military bearing), whereas some of the premier healthcare HRO flagships engage their teams and patients with active, motivational, and energizing signage and decor. While it may seem trivial, signage which is bold, colorful, imaginative, and which tacitly announces “we have pride in our safety and quality” (perhaps with real pictures of smiling people) could help engage our medics and patients in the HR culture. This is a relatively inexpensive way to *feel* the new culture, versus relying only on the *rational* basis for HR.

Other recommendations

Due to constraints in word allowance in the body of this report, I have placed a number of my recommendations in an appendix.

Conclusion

Becoming an HRO is not only a *worthy* goal for the AFMS, but is now a *mandatory* goal pursuant to the SecDef’s directive in 2014. As explained to me by Colonel Lawrence, this effort will likely take longer than many would expect, as transformational changes often do. My goal has been to elucidate my perspective as an agent of change, particular as seen through my eyes as a clinician, educator, commander, and leader. The incorporation of HRT into the framework of the AFMS can be eased by taking into account the stumbling blocks and recommendations I have described above. Ultimately, if HR is as beneficial for AFMS patients as it has been for aircraft carrier success (as we believe it will be), it will undoubtedly be worth the investment in time, money, and manpower. The central issue now is not whether HR is worth the effort or even if it will be pursued, but rather how effectively HR will be strategically implemented enterprise-wide.

Appendix

1. Integrate specific, targeted “safety culture” metrics into the normal repertoire of metrics followed routinely by MTFs. Consider eliminating lesser value-additive metrics to make room (and time) for safety-specific metrics.
2. MTF executive leaders can each adopt a work area outside his/her normal sphere and chain of command.⁴⁴ They can then “own” these areas as HRO advocates and mentors. These area-specific assignments can be rotated on a routine basis if needed, but it would be best to keep the assignments stable for at least a month or longer to allow for fully investing in the areas. This would be akin to LDM daily rounds which are being accomplished at many MTFs, but on a deeper more time-intensive scale than LDM’s short five-minute stops amidst a consistently rotating schedule of leaders.
3. Ensure Airmen have a “protective envelope of human thought” regarding new ideas, reporting of errors, etc.⁴⁵ This is prudent, in contrast to the sentiment described by John Johns in his “Guidelines for Loyal Dissent in Government,” in which he states, “Personally, I have found that some of my bosses who waxed the most eloquent for subordinates to speak their minds were in fact the most intolerant of dissent.”⁴⁶ If Airmen are asked to continually be sensors for threats and potential improvements to safety and quality, they need to feel safe, encouraged, and empowered to speak up accordingly.
4. Robust process improvement (RPI)—which includes Lean, Six Sigma, and change management—is a pivotal aspect of HR in healthcare organizations.⁴⁷ Therefore, I believe it would be beneficial to institute enterprise-wide training in RPI at the soonest possible time. There is probably much to be lost in waiting.

5. Owing to the importance of the rationale and mandate for HR in the AFMS, no HR-related training should ever be relegated to computer-based training (CBT). I do not need to deeply discuss the few advantages of CBTs (cheap, somewhat easy to track) and numerous disadvantages (do not effectively teach, reinforce a lackadaisical outlook on training, encourage cheating, transmit the message “we’re not too concerned that you really know this, but rather we simply need to track completion”) because they are well-known to all of us. Therefore, insofar as training will be required to bring medical teams up to speed on HR principles and concepts, I strongly advise against the use of Swank, ADLS, JKO, or other CBT methods. If the AFMS defaults to these methods of instruction, the hearts and minds of medics will be lost to it. Real in-person training transmits the message, “The AFMS really cares about this,” whereas broadcasting the training via CBT transmits, “This is not worth the AFMS’s time”.
6. Ensure rewards are given⁴⁸ for the discovery of incipient errors in the workplace, helping to secure the involvement and buy-in of Airmen.⁴⁹ These need not be concrete rewards, provided they connect with the medic in a tangible, emotional way. Vocal recognition not only by commanders at their calls (which is absolutely worthwhile) but also by peers at weekly flight meetings or daily team meetings has worked well for me in the past for building team cohesion and instilling pride in a job well done. Being recognized *by* peers *in front of* peers can make a deeper impact than public recognition at formal commander’s calls, yet this is often forgotten and/or not used. As a squadron commander, I decided at one of my monthly all-squadron meetings (which were less formal than my commander’s calls) to ask the simple question, “Can anyone mention a specific example of a time this week in which a teammate sacrificially went out of his/her

way to help make your job easier?” As the first response led to the next one and the next one, I was overwhelmed by the number of my Airmen who began complimenting, encouraging, and praising one another for each other’s efforts. People are moved by heart-felt, honest praise, especially by the peers they work with daily. Everyone left the meeting more committed and engaged, and I decided to make this a routine part of my monthly meetings. Notably, the number of responses shared each month did not tend to dwindle as the novelty effect theory might predict. This is just one example of a non-concrete, non-monetary reward strategy, and it would be simple to tailor a similar method to improve team-based commitment to patient safety and HR.

7. In the interest of overcoming inertia (resistance to change), there should be a default institutional skepticism toward the current/former way of operating, at least with regard to patient safety.⁵⁰ Everything should be looked at through the lens of HR. If a particular process is “just the way we’ve always done it”, it should automatically be looked at with suspicion until/unless proven to be a contributor to HR. Otherwise, it should be modified.
8. Some of the potential transformation-induced cynicism can be prevented simply by the words used to describe the change. Unfortunately, it can be all too easy to explain new concepts and ideas in ways that can turn off hearts and minds at a time when they are most needing to be engaged. For example, if Lean principles are being taught and encouraged, statements which are tantamount to saying, “Lean thinking will help us do more with less” are a turn-off for medics who already perceive themselves as working to their capacities. Similarly, “Lean thinking will help us cut costs” does not immediately resonate on a personal level with Airmen. In contrast, if the verbiage can instead be

stated in a way which attracts the listener to the benefits on a *personal* level, the intended buy-in of the team member will be improved. For example: “Lean thinking will help us (and you) eliminate waste—things that waste your time, including extra steps, time, processes, emails, and even length and number of meetings which don’t add value to our team’s goals or our patients’ health.”⁵¹ The difference is minimal, but avoids low-impact, counterproductive phrases such as, “do more with less”, “be more efficient”, and “cost-cutting”, thus potentially creating a more personally-felt connection to the concept. Some of those phrases may pay dividends with upper-level leadership but I suspect they do not typically resonate with mid- and lower-level staff. And sometimes intentionally *not* using terms like Lean and Six Sigma, but rather simply teaching and leading change-based principles of HR, can rally the team around a common cause without creating the hackneyed perception that a(nother) new program or fad is being introduced.

9. In this transformation, as in any, we should make every attempt to focus on what is working well within an MTF, learn from it, and strive to use this “bright spot” as a way to advertise to other areas how they can emulate or clone the success.⁵² This applies to analyzing metrics, in the sense that there is a natural human tendency to overly focus on problem areas (the “red”) instead of drawing attention to the green areas as generators of potential solutions. Heath and Heath describe this common situation as being too “problem-focused” at the expense of not being “solution-focused,”⁵³ leading to missed opportunities for ease of change. MTF leaders should be reminded to ask, “What’s working, and how can we do more of it?” instead of focusing all attention on “What’s broken, and how do we fix it?”⁵⁴

Notes

1. Patricia Kime, "In wake of VA scandal, DoD to review its health system," *Military Times*, 29 May 2014, <http://archive.militarytimes.com/article/20140529/NEWS/305290068/In-wake-VA-scandal-DoD-review-its-health-system/> (accessed 19 October 2015).
2. Chuck Hagel, Secretary of Defense. To Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, et al., 1 October 2014.
3. "The High Reliability Organization Task Force Report: A Resource Guide for Achieving High Reliability in the Military Health System," 4 September 2015, 8.
4. Military Health System Review—Final Report, Appendix 6, "Recommendations and Comments," (29 August 2014), Section 5, p. 150.
5. Ibid, 151.
6. Ibid, 190.
7. Hagel, 1 October 2014.
8. AFMS Trusted Care Transformation Task Force Charter, signed by Lt Gen Mark A. Ediger, USAF Surgeon General, 28 August 2015.
9. Mark R. Chassin and Jerod M. Loeb, "High-Reliability Healthcare: Getting There from Here," *The Milbank Quarterly* 91, no. 3 (2013): 460.
10. Karl E. Weick, Kathleen M. Sutcliffe, and David Obstfeld, "Organizing for High Reliability: Processes of Collective Mindfulness," in *Research in Organizational Behavior*, ed. R.S. Sutton and B.M. Staw (Stanford: Jai Press, 1999), 81-82.
11. Charles Perrow, *Normal Accidents: Living with High Risk Technologies* (New York: Basic Books, 1984), cited by Karl E. Weick, Kathleen M. Sutcliffe, and David Obstfeld, "Organizing for High Reliability: Processes of Collective Mindfulness," in *Research in Organizational Behavior*, ed. R.S. Sutton and B.M. Staw (Stanford: Jai Press, 1999), 82.
12. Weick et al., "Organizing for High Reliability," 82.
13. Ibid, 85.
14. Ibid, 87.
15. John Toussaint, "A Management, Leadership, and Board Road Map to Transforming Care for Patients," *Frontiers of Health Services Management* 29, no. 3 (Spring 2013): 3-15.
16. James P. Womack and Daniel T. Jones. *Lean Thinking* (New York: Free Press, 1996), 268. The authors state, "... getting the critical mass of employees to change their traditional way of thinking requires stern direction as employees are commanded to try things which seem completely crazy."
17. Simon Sinek, "How Great Leaders Inspire Action" (lecture, TED Talks, September 2009). https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action/transcript?language=en/ (accessed 26 October 2015).

18. Colonel Tom D. Miller, former commander, 377th Air Base Wing, Kirtland AFB, New Mexico. At Kirtland's 377th Medical Group (part of a nuclear wing) the definitive answer to the question of "what is the #1 priority" is always "PRP". From the wing commander down to the newest airman, nuclear operations and PRP are always considered the #1 priority. AFMS leaders will need to ensure the HRO concept's touted #1 priority of "patient safety and quality of care" is strategically interwoven within nuclear/PRP circles so there is no perceived mismatch of priorities.

19. Chassin and Loeb, "High-Reliability Healthcare," 459.

20. Toussaint, "A Management, Leadership, and Board Road Map," 4-5.

21. Womack and Jones. *Lean Thinking*, 256, 260. With regard to Lean thinking, the authors discuss the absolute necessity for "a willingness to remove those few managers who will never accept the new way." They go on to state, "... in every successful transition we've examined, change agents, in looking back over their experience, wish they had acted faster to remove managers who would not cooperate." And finally, "Take action quickly to remove those managers who won't give new ideas a fair trial."

22. Todd R. La Porte, "High Reliability Organizations: Unlikely, Demanding and At Risk." *Journal of Contingencies and Crisis Management* 4, no. 2 (June 1996): 60-71.

23. Colonel Linda L. Lawrence, interview by the author, 10 September 2015.

24. Leonard Wong and Stephen Gerras, "Lying to Ourselves: Dishonesty in the Army Profession." *Strategic Studies Institute Report*. Carlisle Barracks, PA: U.S. Army War College Press, 2015.

25. Peter J. Pronovost, et al., "Implementing and Validating a Comprehensive Unit-Based Safety Program." *Journal of Patient Safety* 1 (2005): 33-40. Cited by: Pronovost, Peter J. et al., "Creating High Reliability in Healthcare Organizations." *Health Services Research* 41, no. 4 (August 2006): 1610.

26. Weick et al., "Organizing for High Reliability," 85-86.

27. La Porte, "High Reliability Organizations," 69.

28. M.M. Shabot, et al., "Memorial Hermann: High Reliability from Board to Bedside," *Joint Commission Journal on Quality and Patient Safety* 39, no. 6 (June 2013): 253-257.

29. Toussaint, "A Management, Leadership, and Board Road Map," 14.

30. Mark R. Chassin and Jerod M. Loeb, "The Ongoing Quality Improvement Journey: Next Stop, High Reliability," *Health Affairs* 30, no. 4 (April 2011): 559.

31. Toussaint, "A Management, Leadership, and Board Road Map," 10.

32. Chassin and Loeb, "High-Reliability Healthcare," 476.

33. Major General Gar S. Graham, retired, former chief, U.S. Air Force Dental Corps

34. Chassin and Loeb, "High-Reliability Healthcare," 476.

35. Institute for Safe Medicine Practices. "Intimidation: Practitioners Speak Up about This Unresolved Problem—Part I." *ISMP Medication Safety Alert* 9, no 5. (2004): 1-3. Cited by:

Chassin, Mark R. and Jerod M. Loeb. "High-Reliability Healthcare: Getting There from Here." *The Milbank Quarterly* 91, no. 3 (2013): 459-490.

36. Maimonides Medical Center "Code of Mutual Respect", 2009.
<http://www.maimonidesmed.org/Resource.ashx?sn=codeofmutualrespectrev709>. Cited by:
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37. Karlene Kerfoot. "Reliability Between Nurse Managers: The Key to the High-Reliability Organization." *Nursing Economics* 24, no. 5 (August 2007): 273.

38. Paul O'Neill. "The Irreducible Components of Leadership Needed to Achieve Continuous Learning and Continuous Improvement." Lecture, *Value Capture*, 2009.
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39. Weick et al., "Organizing for High Reliability," 38.

40. Ibid, 85-86.

41. "Continuous Process Improvement / Lean Six Sigma Guidebook, Section 2. DoD CPI Framework," U.S. Department of Defense, July 2008, 2-2.

42. Womack and Jones. *Lean Thinking*, 15-16.

43. Chassin and Loeb, "High-Reliability Healthcare," 481-483.

44. Pronovost, "Implementing and Validating," 1603.

45. Weick et al., "Organizing for High Reliability," 36.

46. John H. Johns "Guidelines for Loyal Dissent in Government." In: *Beyond a Government of Strangers: How Career Executives and Political Appointees Can Turn Conflict to Cooperation*, by Robert Maranto. (Lanham, MD: Lexington Books, 2005).

47. Chassin and Loeb, "The Ongoing Quality Improvement Journey," 565.

48. Womack and Jones, *Lean Thinking*, 261. The authors state the need to "keep score and reward your people," as well as the importance of giving bonuses tied directly to profitability. Granted, bonuses and profitability are not typically terms discussed in MTFs nor are bonuses even applicable for the most part, but some sort of non-monetary bonuses can pack a big punch in motivating staff.

49. La Porte, "High Reliability Organizations," 64.

50. Ibid, 67.

51. Womack and Jones, *Lean Thinking*, 15.

52. Chip Heath and Dan Heath, *Switch: How to Change Things When Change is Hard*. (New York: Broadway Books, 2010), 45-48, 98.

53. Ibid, 48.

54. Ibid, 45.

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